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MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM: Dr. Craigan L. Gray
Leza Wainwright

SUBJECT: SPECIAL Implementation Update #60: Legislative Changes
Community Support and other MH/DD/SAS
LME Role in CS Service Transition
Community Support Team
Residential Level III & Level IV Services
Case Management Workgroup
Medicaid Card Changes
Electronic Claims Submission
Electronic Funds Transfer
Medicaid Provider Payment Suspension
Appeals
State Funds Supplementing CAP-MR/DD Services

This special Implementation Update outlines the policy changes required to implement the provisions set forth in Session Law 2009-451, signed into law on August 7, 2009 related to Medicaid-funded behavioral health services, as well as, Health Choice and State funded services. Section citations provide the statutory authority for these policy changes which can be found at: http://www.ncleg.net/Sessions/2009/Bills/Senate/PDF/S202v8.pdf . This special Implementation Update will serve in lieu of the September Implementation Update.

Community Support and other Mental Health, Developmental Disability, Substance Abuse Services
SECTION 10.68.A.(a)(5)(b) and (c)
Effective October 12, 2009, for Medicaid, Health Choice and State-funded services, no new admissions for individual or group Community Support services shall be authorized. However, Local Management Entities (LME) may restrict admissions prior to the effective date in this memo for State funded Community Support services. Any new State- funded Community Support service requests will be subject to LME availability of funds.

Effective June 30, 2010, Community Support services will not be a covered service under the NC State Medicaid Plan. Requests for Community Support services for children must follow the established Early and Periodic Screening,

Diagnosis, and Treatment (EPSDT) procedures and requirements, which are available at http://www.dhhs.state.nc.us/dma/epsdt.

Authorizations for Medicaid and State-funded Community Support services currently in effect as of the date of this memo will remain valid until the current authorization expires.

SECTION 10.68.A.(a)(5)(d)
Effective October 12, 2009, Community Support services cannot be provided in conjunction with any of the following enhanced services:

- Intensive In-Home Services
- Multisystemic Therapy
- Assertive Community Treatment Team
- Community Support Team
- Substance Abuse Intensive Outpatient Program
- Substance Abuse Comprehensive Outpatient Treatment
- Child and Adolescent Day Treatment
- Psychosocial Rehabilitation
- Opioid Treatment
- SA Medically-Monitored Community Residential Treatment
- SA Non-Medical Community Residential Treatment
- Partial Hospitalization

The providers of the following enhanced services that do not include clinical home functions,

- Child and Adolescent Day Treatment,
- Psychosocial Rehabilitation,
- Opioid Treatment,
- SA Medically-Monitored Community Residential Treatment,
- SA Non-Medical Community Residential Treatment, and
- Partial Hospitalization

will be responsible for the following activities:

- The development and implementation of the Person Centered Plan (PCP) including the crisis plan. A qualified professional delivering the service is responsible for the development of the PCP. As a part of the crisis plan, the provider must coordinate with the LME and recipient to identify local crisis services that can be accessed.
- Submission of the applicable request for authorization form and supporting documentation to ValueOptions or the LME.
- Submission of the Consumer Admission form to the LME.

If a recipient receives more than one non-clinical home service, e.g. Psychosocial Rehabilitation and Opioid treatment, it is expected that the providers will work together to coordinate services.

Effective September 28, 2009, qualified professional level (licensed professional and qualified professional) Community Support may be provided to a child in Residential Level III and IV to assist in discharge planning. The qualified professional may provide up to a maximum of 96 units (24 hours) of case management functions over a 90-day authorization period as approved by Value Options or the LME.

SECTION 10.68.A.(a)(5)(e)
The current moratorium on Community Support provider endorsement remains in effect.

SECTION 10.68.A.(a)(5)(f)
A provider of Community Support services whose endorsement has been withdrawn or whose Medicaid participation has been terminated is not entitled to payment during the period the appeal is pending, and the Division of Medical Assistance (DMA) shall make no payment to the provider during that period. If the final agency decision is in favor of the provider, DMA shall remove the suspension, commence payment for valid claims, and reimburse the provider for payments withheld during the period of appeal.

SECTION 10.68.A.(a)(5)(g)
Effective October 12, 2009, the paraprofessional (PP) level of Community Support will be eliminated, and from this date DMA and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) shall not use any Medicaid or State funds to pay for this level of service.

SECTION 10.68.A.(a)(5)(h)
Effective September 28, 2009 any concurrent (reauthorization) requests are subject to the following:

1. The request may not exceed 90 days.
2. The request must be accompanied by a discharge plan. The discharge plan is a required document for a request to be considered complete, the approved forms are found in Attachment A for children and Attachment B for adults. Failure to submit the discharge plan to ValueOptions (VO) or the LME will result in the request being returned as "Unable to Process."
3. The discharge plan must indicate that discharge from the service will occur within that authorization period.

Policy for New Requests for Community Support
Effective September 28, 2009 any new requests for Community Support (not applicable after October 12, 2009) are subject to the following:

1. The request may not exceed 90 days.
2. The request must be accompanied by a discharge plan. The discharge plan is a required document for a request to be considered complete, the approved forms are found in Attachment A for children and Attachment B for adults. Failure to submit the discharge plan to ValueOptions (VO) or the LME will result in the request being returned as "Unable to Process."
3. The discharge plan must indicate that discharge from the service will occur within that authorization period.

SECTION 10.68.A.(a)(5)(i)(j)(k)
Any Community Support provider that ceases to function as a provider shall provide written notification to DMA, the Local Management Entity, recipients, and the prior authorization vendor 30 days prior to closing of the business.

Medical and financial record retention is the responsibility of the provider and shall be in compliance with the record retention requirements of their Medicaid provider agreement or State funded services contract. Records shall also be available to state, federal, and local agencies.

Failure to comply with notification, recipient transition planning, or record maintenance shall result in suspension of further payment until such failure is corrected. In addition, failure to comply shall result in denial of enrollment as a provider for any Medicaid or State funded service. A provider (including its officers, directors, agents, or managing employees or individuals or entities having a direct or indirect ownership interest or control interest of five percent (5%) or more as set forth in Title XI of the Social Security Act) that fails to comply with the required record retention may be subject to sanctions, including exclusion from further participation in the Medicaid program, as set forth in Title XI.

LME Role in Community Support Service Transition
To prepare for the Community Support transition Local Management Entities will need to:

- Provide notice to all Community Support providers regarding the changes in policies affecting Community Support services.
- Work closely with providers of Community Support services, particularly those that serve high risk consumers.
- Collaborate with providers to ensure consumers are appropriately triaged.
- Assess workforce and service development needs.

Community Support providers within a given catchment area will need to be aware of alternative services that consumers can transition to including but not limited to:

- Provisionally licensed professionals with LME contracts
- Licensed professionals
- Medicaid-enrolled psychiatrists/psychologists
- Primary care providers
- Other enhanced service providers

In addition, the LME will need to work diligently within their provider networks to develop plans on expanded service capacity.

Community Support Team – SECTION 10.68.A.(a)(6)
Effective September 28, 2009, all new authorizations for Community Support Team (CST) shall be based upon medical necessity as defined by the DMA Clinical Coverage Policy 8A and shall not exceed 18 hours per week. Requests received by ValueOptions and LMEs for more than 18 hours per week shall be returned as "Unable to Process." As of the date of this memo, existing authorizations for CST will remain effective until the end of the current authorization period. Effective September 28, 2009, if an adverse decision is appealed, maintenance of services shall not exceed the 18 hour service limit.
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Residential Level III and Level IV Services for Children

SECTION 10.68.A.(a)(7)(c)
All Medicaid funded child mental health, developmental disability and substance abuse residential service providers (Level II-program type, III and IV) are required to be nationally accredited by August 7, 2010 (one year from date of enactment of the legislation).

SECTION 10.68.A.(a)(7)(b) (d)(e)(f)
Authorizations currently in effect for Level III and Level IV residential services remain valid. Effective September 28, 2009, the following criteria must be met for new admissions to Level III or Level IV child residential services:

1. The current provider and the LME System of Care Coordinator (SOC) will convene the Child and Family Team (CFT).
2. The Child and Family Team shall review a current comprehensive clinical assessment that includes a discussion of all life domains (emotional, social, safety, housing, medical and health, educational, vocational, and legal).
3. The Child and Family Team shall fully inform the youth and family of all service options.
4. The Child and Family Team must develop a discharge plan on the approved DMH/DD/SAS and DMA Discharge Plan found in Attachment A.
5. The discharge plan shall be submitted as part of the initial or reauthorization request for all child residential services. Submission of the discharge plan is required in order for the request to be considered complete. Failure to submit a complete discharge plan will result in the request being returned as "Unable to Process."

The CFT in developing the Person Centered Plan shall promote least restrictive services in the home (such as Intensive In-Home or Multisytemic Therapy) prior to residential placement. During treatment there must be inclusion in community activities and parent or legal guardian participation in treatment.

In addition to the current eligibility criteria documented in DMA Clinical Coverage Policy 8D-2, before a child can be admitted to Level III or Level IV placement the following shall apply:

1. Placement may be a transition from a Psychiatric Residential Treatment Facility (PRTF) or inpatient setting
   OR
2. Multisystemic Therapy (MST) or Intensive In-Home (IIH) services did not meet the youth's treatment needs within the last six months and severe functional impairments persist;
   AND
3. The CFT has reviewed all other alternatives and recommendations and recommends Level III or IV residential placement due to maintaining the health and safety of the child.

For all new admissions to child residential services, length of stay is limited to no more than 120 days. All requests for a new admission must include a discharge plan in order for the request to be considered complete. Failure to submit a complete discharge plan will result in the request being returned as "Unable to Process."

As of September 28, 2009, all concurrent authorizations are limited to a maximum of 90 days after the current authorization expires. All concurrent authorization requests require the following:

1. A new comprehensive clinical assessment (that addresses co-occurring disorders as appropriate) by a psychiatrist (independent of the residential provider and its provider organization) that includes clinical justification for continued stay at this level of care.
2. The CFT will review goals and treatment progress.
3. Family and/or caregivers are actively engaged in treatment goals and objectives.
4. A revised discharge plan.

The psychiatric assessment justifying the request and a revised discharge plan must be submitted to ValueOptions with the ITR and Person Centered Plan revision including documentation of the review of the CFT. The Person Centered Plan must reflect the family and/or caregiver involvement in treatment. Failure to submit the psychiatric assessment and the revised discharge plan will result in the request being returned as "Unable to Process."

Requests for Level III and Level IV residential services for children must follow the established Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) procedures and requirements, which are available at http://www.dhhs.state.nc.us/dma/epsdt.

SECTION 10.68.A.(a)(7(g)(h)(i)
Any residential provider that ceases to function as a provider shall provide written notification to DMA, the Local Management Entity, recipients, and ValueOptions 30 days prior to closing of the business. Record maintenance is the

responsibility of the provider and must be in compliance with record retention requirements. Records shall also be available to state, federal, and local agencies. Failure to comply with notification, recipient transition planning, or record maintenance shall be grounds for withholding payment until such activity is concluded. In addition, failure to comply shall be conditions that prevent enrollment for any Medicaid or State-funded service.

Case Management Workgroup

To address the reduction in funds for Medicaid Case Management services, DMA has convened a steering committee with representatives from other Department of Health and Human Services (DHHS) divisions, providers, recipients' family members and advocates, to identify ways to improve the efficiency and effectiveness of case management services. For up-to-date information on this initiative, please go to the DMA website at http://www.ncdhhs.gov/dma/provider/MedicaidCaseManagement.htm. Providers can review meeting agendas, minutes, meeting handouts and working documents as well as data reports and an overview of current Medicaid-funded Case Management services. Please check this site frequently to stay current on developments.

Medicaid Card Changes

Changes related to new annual Medicaid cards for recipients were presented in the September 2009 Medicaid Bulletin, which was published on the DMA website on September 1, 2009. Please be sure to review the information in the article carefully. Medicaid Bulletins may be accessed at http://www.ncdhhs.gov/dma/bulletin/.

Electronic Claims Submission

Under Section 10.64A(a)(1)(a)and (b) DHHS is directed to take actions to achieve required budget reductions, including the requirement for providers to both receive payment and submit claims electronically. The implementation date and other requirements for the Electronic Claims Submission were available in the September 2009 Medicaid Bulletin, which may be accessed at the web address above.

Electronic Funds Transfer Requirement

Effective with the second checkwrite in September (September 15, 2009) the N.C. Medicaid Program will no longer issue paper checks for claims payment. All payments will be made electronically by automatic deposit to the account specified in the provider's Electronic Funds Transfer (EFT) Authorization Agreement for Automatic Deposits.

Providers were first notified of this cost-saving measure in the June 2009 Medicaid Bulletin. Additional information about the electronic funds transfer requirement and other budget initiatives are available on DMA's Budget Initiatives web page at http://www.ncdhhs.gov/dma/provider/budgetinitiatives.htm.

Providers who are currently receiving paper checks for claims payment must complete and submit an EFT Authorization Agreement for Automatic Deposits immediately to ensure that there is no disruption to payments. The form is available on DMA's website at http://www.ncdhhs.gov/dma/provider/forms.htm.

Once the EFT Authorization Agreement has been submitted, a test with the bank will be performed to validate the account information. This test will be done on the first checkwrite in which financial activity occurs, following receipt of the completed form. Normally it will require one checkwrite to complete the process. Once the testing process is complete, payments will be electronically deposited directly to the provider's bank account one business day after the checkwrite day.

Appeals

Session Law 2009-526, signed into law on August 26, 2009, makes various clarifying changes to the requirements of the Medicaid Fair Hearing and Appeals process. Changes are summarized below. Refer to Session Law 2009-526 at http://www.ncleg.net/enactedlegislation/sessionlaws/pdf.2009-2010/sl2009-526.pdf for full details.

Section 2 (a) changes the effective date of an adverse decision from 30 to **10 days** from the date the notice of decision was mailed. (The date the notice is mailed is the date of the notice). This section also states that where a request for hearing concerns an adverse decision related to Medicaid recipient services, upon the receipt of a timely appeal, the DHHS shall reinstate the services to the level or manner prior to action by the DHHS as permitted by federal law or regulation. This means that if the recipient or his/her guardian request the appeal within 10 days of the date the notice was mailed and the recipient was receiving services the day before the notice was mailed, services will continue under maintenance of service. Should the recipient request a hearing 11 to 30 days from the date the notice was mailed and was receiving services the day before the notice was mailed, there could be a delay in payment for the service beginning day 11 from the date the notice was mailed to the date the appeal is received by the Office of Administrative Hearings (OAH) and the DHHS. Once the appeal request is filed and received by OAH and DHHS, services will be reinstated and will continue under maintenance of services as long as the recipient remains Medicaid eligible.

Section 10.15A.(h2) provides that to the extent possible, the OAH shall schedule and hear all contested Medicaid cases within **55 days** of submission of a request for appeal. (The previous requirement was 45 days).

In addition, all Medicaid hearings shall be conducted telephonically or by video technology, unless the recipient or applicant, or representative, requests an in-person hearing. An in-person hearing shall be conducted in Wake County; however, for good cause shown, the in-person hearing may be conducted in the county of residence of the recipient or applicant. Please see Session Law 2009-526 at the website above for a definition of good cause and written notification requirements.

Continuances shall only be granted in accordance with OAH rules and shall not be granted on the day of the hearing, except for good cause shown. If a petitioner fails to make an appearance at a hearing that has been properly noticed via certified mail by the OAH, the OAH shall immediately dismiss the contested case.

Mediation Timeframes and Processes
Session Law 2009-526 requires that if the parties have resolved matters in the mediation, the case shall be dismissed by the OAH. The OAH shall not conduct any contested Medicaid cases hearings until it has received notice from the mediator assigned that either:

- the mediation was unsuccessful, or
- the petitioner has rejected the offer of mediation, or
- the petitioner has failed to appear at a scheduled mediation.

New Evidence
The petitioner shall be permitted to submit evidence regardless of whether obtained prior to or subsequent to the DHHS actions and regardless of whether the DHHS had an opportunity to consider the evidence in making its determination to deny, reduce, terminate or suspend a benefit. When such evidence is received, at the request of the DHHS, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days to allow the Department to review the evidence. Subsequent to review of the evidence, if the DHHS reverses its original decision, it shall immediately inform the administrative law judge.

Issue for Hearing
For each penalty imposed or benefit reduced, terminated, or suspended, the hearing shall determine whether the DHHS substantially prejudiced the rights of the petitioner and if the DHHS, based upon evidence at the hearing:
Exceeded its authority or jurisdiction; acted erroneously; failed to use proper procedure; acted arbitrarily or capriciously; or failed to act as required by law or rule.

Section10.15A.(e2) clarifies that the community support provider appeals process shall be developed and implemented as follows:

- Hearings are to be held in Wake County, except that the hearing officer may take testimony and receive evidence by telephone or other means. The petitioner and the petitioner's legal representative may appear before the hearing officer in Wake County.
- Parties are no longer required to exchange copies of documentary evidence prior to the hearing.
- The appeal hearing shall be recorded and if a petition for judicial review is filed the Department shall include a copy of the recording of the hearing as part of the official record.
- The final decision shall be rendered not more than 180 days (previously 90 days) from the date of the filing of the petition.

Information
As it becomes available, further information about the Medicaid recipient appeal process will be published in the Medicaid Bulletins. Questions regarding the Medicaid recipient appeal process may be directed to OAH (919-431-300), the toll-free CARE-LINE, Information and Referral Services (1-800-662-7030), 7:00 a.m.-11:00 p.m., or DMA (919-855-4260).

Medicaid Provider Payment Suspension
Session Law 2009-451, SECTION 10.73A.(a)(b)(c)
DHHS may suspend payment to any North Carolina Medicaid provider against whom DMA has instituted a recoupment action, termination of the NC Medicaid Administrative Participation Agreement, or referral to the Medicaid Fraud Investigations Unit of the North Carolina Attorney General's Office. The suspension of payment shall be in the amount under review and shall continue during the pendency of any appeal filed at the DHHS, the OAH, or State or federal courts. If the provider appeals the final agency decision and the decision is in favor of the provider, the DHHS shall reimburse the provider for payments for all valid claims suspended during the period of appeal.

Entering into a Medicaid Participation Agreement with DHHS does not give rise to any property or liberty right in continued participation as a provider in the North Carolina Medicaid program.

DHHS shall not make any payment to a provider unless and until all outstanding Medicaid recoupments, assessments, or overpayments have been repaid in full to DHHS, together with any applicable penalty and interest charges, or unless and until the provider has entered into an approved payment plan.

State Funds Supplementing CAP-MR/DD Services
SECTION 10.21B

As was discussed in Implementation Update (IU) #59, the General Assembly did impose restrictions on the use of state funds to supplement the benefits that CAP-MR/DD recipients receive through the waiver. Most waiver recipients may only continue to receive State-funded services when there is not a comparable service available in the waiver. Those services are "limited to guardianship, room and board, and time-limited supplemental staffing to stabilize residential placement." There is an exception for former Thomas S. consumers. Those individuals may continue to receive a broader array of State-funded consumers, based upon the LME's authorization. In order to come into compliance with this limitation, all LMEs should complete their review of the State-funded services being received by waiver recipients no later than October 1, 2009. As noted in IU # 59, LMEs should not reduce or terminate State-funded services if a revised Person Centered Plan has been submitted to ValueOptions until the revised plan has time to be processed.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

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